LOUDOUN COUNTY GOVERNMENT
Americans with Disabilities Act (ADA)
Reasonable Accommodation Request Form

It may be helpful to discuss the essential functions of your position with your supervisor or a member of the County's Department of Human Resources ("DHR") staff to explore accommodations that would assist you in performing the essential functions of your job. You may also contact DHR if you have any questions regarding the ADA or the process for requesting a reasonable accommodation.

In order to determine whether you are eligible for an accommodation, DHR staff may request documentation of your medical condition in the form of a healthcare provider statement describing the medical condition that necessitates the position accommodation. The medical information completed by your healthcare provider will be confidential but may be shared with individuals who have a legitimate operational need to know this information. You are consenting to this sharing of information by signing the release below.

Employee Information

_____
Date of Request

_____ _____
Employee's Name (Please print) Job Title/Position Number

_____ _____
Department/Division Phone Number

_____ _____
Supervisor Phone Number

Reason for Request:

1. Describe in detail the accommodation you are requesting.

2. Describe how your condition limits your ability to perform the essential functions of your job.

3. If you are requesting a specific accommodation, how will that accommodation assist you in performing the essential functions of your job?

4. Do you need assistance to identify accommodations that will enable you to perform the essential functions of your job?

5. Provide any information on how the requested accommodation(s) can be provided. If appropriate, include the names, addresses and telephone numbers of vendors and the model name or number for specific equipment, if known.

Employee Signature

I certify that the information given on this form is true. I understand that making false statements on this form is grounds for discipline up to and including termination of my employment.

_____

Employee Signature Date

Release of Information

I authorize my health care provider (s) _____to release information to and, if necessary, speak with the Loudoun County DHR staff about my medical condition for the purpose of determining appropriate job accommodations(s) for my condition. My medical information is confidential and therefore will be shared only with individuals on a need to know basis.

_____

Employee Signature Date